#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345353	B. WING	_			R
NAME OF I	PROVIDER OR SUPPLIER	34333	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	03/2014
NAIVIE OF F	-ROVIDER OR SUFFLIER				700 PAMALEE DRIVE		
HIGHLAN	ND HOUSE REHABILI	TATION AND HEALTHCARE			AYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	ΓS	{F 00	00}			
F 431	Regulation, Nursing Certification Section facility was found to 09/03/2014.	e Division of Health Services g Home Licensure and n conducted a revisit. The b be in compliance effective	F 4	121			9/8/14
SS=B	( ), ( ), ( )	UGS & BIOLOGICALS	Г4	101			9/0/14
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order	nploy or obtain the services of sist who establishes a system of and disposition of all sufficient detail to enable antion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordant professional princip appropriate access	als used in the facility must be not with currently accepted ples, and include the ory and cautionary e expiration date when					
	facility must store a locked compartmer	State and Federal laws, the II drugs and biologicals in the under proper temperature to only authorized personnel to keys.					
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the					

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/23/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345353	B. WING			09/0	⋜ 03/2014
	PROVIDER OR SUPPLIER	TATION AND HEALTHCARE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 700 PAMALEE DRIVE FAYETTEVILLE, NC 28301		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From particle quantity stored is more readily detected.  This REQUIREMENT by: Based on observation of the stated the Advair Diskus inhale at the stated the Advair Diskus indicator reading at the stated the Advair Diskus inhale at the stated the Advair Diskus inhale at the Advair Diskus inhale at the stated the Advair Diskus inhale at the state at the state at the Advair Diskus inhale at the state at the stat	ge 1 inimal and a missing dose can  NT is not met as evidenced ions, record reviews and staff ty failed to discard expired ers in 2 (A hall medication cart in cart #4) of 8 medication  ed: fications for Advair Diskus card Advair Diskus one month from the pouch, or after the s '0', whichever comes first."  ne A hall medication cart #3 on with Nurse #1 in attendance Advair Diskus for Resident # ate of 7/29/14. Nurse #1 iskus inhaler should be after opening.  ne A hall medication cart #4 on ith Nurse #2 in attendance vair Diskus inhaler with an	F 4	31	F000 Disclaimer Highland House Rehabilitation & Healthcare submits this Plan of Co (PoC) in accordance with specific regulatory requirements. It shall no construed as an admission of any a deficiency cited. The Provider subn PoC with the intention that it be inadmissible by any third party in a or criminal action against the Provi any employee, agent, officer, direct shareholder of the Provider. The Pl hereby reserves the right to challer findings of this survey if at any time Provider determines that the disput findings: (1) are relied upon to adve influence or serve as a basis, in an for the selection and/or imposition of future remedies, or for any increase future remedies, whether such rem are imposed by the Centers for Me and Medicaid Services (CMS), the	rrection t be alleged nits this ny civil der or tor, or rovider nge the e the ted tersely y way, of e in tedies dicare State	
	During an interview #2 stated it was the nurses to remove e medication cart. Sh	4 for Resident # 68  on 9/3/14 at 3:35 pm, Nurse responsibility of all of the xpired medications from the e further stated she was not air Diskus inhaler expired after			of North Carolina or any other entity serve, in any way, to facilitate or production by any third party against the Provider. Any changes to Provider or procedures should be considered subsequent remedial measures as concept is employed in Rule 407 of Federal Rules of Evidence and should make the constitution of the constitu	omote policy d to be that f the puld be	

Facility ID: 923255

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED			
						R	
		345353	B. WING		09/	03/2014	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
	ID HOUSE DELIABIL	TATION AND LIEAUTHOADE		1700 PAMALEE DRIVE			
HIGHLAI	ND HOUSE REHABILI	TATION AND HEALTHCARE		FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 431 Continued From page 2 In an interview on 9/3/14 at 3:38 pm, the Director of Nursing stated it was her expectation for the		F 4	basis.				
	nurses to remove e medication carts.	expired medications from the		F431			
				It is the policy and normal pra- facility to label drugs and biol accordance with currently acc professional principles and in appropriate accessory and ca instructions and the expiration applicable.	ogicals in cepted clude the autionary		
				Corrective Action Identified Resident(s):	d		
				A) The Advair discus for Reand Resident #68 was remove medication cart immediately I nurse. Date completed: Sep 2014	red from the by the unit		
				2. Corrective Action Potentia	, ,		
				A) For all residents having the tobe affected by the same properties action was accompare-checking each medication medication expiration and podiscard dates. This task was by Southern PharmacyOs- Not Consultant and Quality Assur Specialist on September 5, 2	ractice the blished by cart for tential completed urse ance		
				3. Systematic Changes:			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245252	B. WING			R	
NAME OF I	PROVIDER OR SUPPLIER	345353	B. WING	CTDEET ADDRESS CITY STATE ZID COS		03/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 1700 PAMALEE DRIVE	)E		
HIGHLAI	ND HOUSE REHABILI	TATION AND HEALTHCARE		FAYETTEVILLE, NC 28301			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 431	Continued From pa	ge 3	F 4	A) The Pharmacy will now in on all medications that have a manufacturer recommended discard date that maybe differ manufacturerOs labeled expiralert the nurse to include: 1) The medication was opened and 2 applicable discard date utilizing Pharmacy Expiration Medication of provided by Southern Pharmacy located in each medication caprocess was initiated: 9/4/20.  B) A step by step procedure developed by the Nurse Consultant at how to properly label these or medications with the date open discard date utilizing the Pharmacy Nurse Consultant at how to properly label these or medications with the date open discard date utilizing the Pharmacy Date produced 9/4/2014.  C) Licensed nurses were instructed above in the PharmacyOs- Nurse Consultant and PharmacyOs- Nurse Consultant and ADON begin 09/04/24.  4. Quality Assurance:  A) Night shift licensed nurses continue to check the carts are areas for expiration dates on a Date completed: September 3.  B) The DON, ADON and/or I	once opened ent from the ation date to the date the end is ting the on listing to that is rt. Date 14.  was ultant(s), and DON on the opened end and macy rovided by ocess was serviced on item 3.B. by sultant, rdinator, nning on end and storage a daily basis. B, 2014		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			X3) DATE SURVEY COMPLETED			
		345353	B. WING			F ng/r	R 03/2014
	PROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 700 PAMALEE DRIVE AYETTEVILLE, NC 28301	1 03/0	33/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa	age 4	F 4	131	Consultant will check the medication weekly for 4 weeks to assure all medications that require a label as in Item 3. A. for 1) The pharmacy late The date the medication was open applicable) and 3) The date the medication is to be discarded (if applicable). A tool was developed record these results. Medication cainspections initiated on September 2014 and will be ongoing for 4 wee.  C) The Pharmacy consultant will continue to check the medication cand storage areas on a monthly baassure compliance with the process Item 3. A. as well as any expired medications that should be discard These findings will be reported to the DON at the end of each visit. The Edesignee will report findings month the Quality Assurance Committee (for four months to monitor effective the plan. Any instances of noncom will be analyzed to determine when occurred; how they occurred and woccurred and responsive action will taken.  D) The medication carts and stora areas will also be inspected by the Consultant during routine visits for months. These findings will be reported to the Quality Assurance Committee (QAA) for four months monitor effectiveness of the plan. Any monitor effectiveness of the plan.	noted abel, 2) ed (if to art 4, ks.  arts sis to s in ed. ne DON/or ly to QAA) eness of pliance they why they I be  age Nurse 2 orted e end e to to	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  HIGHLAND HOUSE REHABILITATION AND HEALTHCARE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS  TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 431  (S5)  COMPLETION DATE  F 431  instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.  Complete Date: 09/08/14	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HIGHLAND HOUSE REHABILITATION AND HEALTHCARE    STREET ADDRESS, CITY, STATE, ZIP CODE   1700 PAMALEE DRIVE   FAYETTEVILLE, NC 28301			345353					
HIGHLAND HOUSE REHABILITATION AND HEALTHCARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 431 Continued From page 5  F 431 instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.	NAME OF I	200//DED OD 01/DD1/ED	040000	15: ******		7ID 00DE	09/0	J3/2U14
Cate   Design   Continued From page 5   F 431   F 431   Continued From page 5   F 431   F 43	NAME OF PROVIDER OR SUPPLIER					ZIP CODE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 431 Continued From page 5	HIGHI AI	ND HOUSE REHABILI	TATION AND HEAI THCARE					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 431  Continued From page 5  F 431  Continued From page 5  F 431  F 431  Continued From page 5  F 431					FAYETTEVILLE, NC 28301			
instances of noncompliance will be analyzed to determine when they occurred; how they occurred and why they occurred and responsive action will be taken.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			BE	COMPLETION		
	F 431	Continued From pa	ge 5	F 4	instances of noncompli analyzed to determine to occurred; how they occ occurred and responsive taken.	when they urred and w re action will	hy they	